This form must be completed electronically when possible. Handwritten forms will be accepted.

EBOLA VIRUS DISEASE EXPOSURE RISK EVALUATION
(IN THEATER USE ONLY)

OMB No. 0720-
OMB approval expires

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting the personal information requested by this form and how it may be used.

AUTHORITY: 10 U.S.C. 1074f, Medical Tracking System for Members Deployed Overseas; 42 U.S.C. 264-272, Quarantine and Inspection, Executive Order 13295, Revised List of Quarantinable Communicable Diseases; 42 CFR Part 70, Interstate Quarantine; 42 CFR Part 71, Foreign Quarantine; DoDI 6490.03, Deployment Health; and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): Your information may be used for the purpose of collecting certain communicable disease(s) data IAW regulations providing for the apprehension, detention, or conditional release of individuals to prevent the introduction, transmission, or spread of suspected communicable diseases, pursuant to section 361(b) of the Public Health Service Act. Your information will be collected in order to identify any health concerns and, if necessary, refer you for additional assessment and/or care.

ROUTINE USE(S): Use and disclosure of your records outside of DoD may occur in accordance with the DoD Blanket Routine Uses published at: http://dpclo.defense.gov/privacy/SORNsIndex/BlanketRoutineUses.aspx and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)).

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, healthcare operations, and the containment of certain communicable diseases.

DISCLOSURE: Mandatory. To protect the health of the public from Ebola, a highly infectious virus of significant public health threat, you are hereby required to provide the requested information. Care will not be denied if you decline to provide the requested information, but you may not receive the care you deserve and may face administrative delays.

INSTRUCTIONS: **DoD personnel must IMMEDIATELY report any potential Ebola Virus Disease [EVD] exposure while deployed in an Ebola outbreak country or region. Prompt medical evaluation is critical.** You are required to truthfully answer all questions. Failure to disclose the requested medical information regarding potential EVD contact or exposure risks while deployed to an Ebola outbreak area may result in UCMJ and/or criminal punishment. If you do not understand a question, please discuss the question with a healthcare provider.

DEMOGRAPHICS

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Social Security Number: _____ **Today's Date (dd/mmm/yyyy):** _____

Date of Birth (dd/mmm/yyyy): _____ **Gender:** ◯ Male ◯ Female

Service Branch:
- ◯ Air Force
- ◯ Army
- ◯ Navy
- ◯ Marine Corps
- ◯ Coast Guard
- ◯ Civilian Expeditionary Workforce
- ◯ USPHS
- ◯ Other Defense Agency (List): _____
- ◯ Other (List): _____

Component:
- ◯ Active Duty
- ◯ National Guard
- ◯ Reserves
- ◯ Civilian Government Employee
- ◯ Contractor

Pay Grade:
- ◯ E1
- ◯ E2
- ◯ E3
- ◯ E4
- ◯ E5
- ◯ E6
- ◯ E7
- ◯ E8
- ◯ E9
- ◯ O1
- ◯ O2
- ◯ O3
- ◯ O4
- ◯ O5
- ◯ O6
- ◯ O7
- ◯ O8
- ◯ O9
- ◯ O10
- ◯ W1
- ◯ W2
- ◯ W3
- ◯ W4
- ◯ W5
- ◯ Other

Home Station/Unit: _____

Current Contact Information:

Phone: _____

Cell: _____

DSN: _____

Email: _____

Address: _____

Point of contact who can always reach you:

Name: _____

Phone: _____

Email: _____

Address: _____

Deployment location(s): ◯ Liberia ◯ Sierra Leone ◯ Guinea ◯ Senegal ◯ Nigeria ◯ Other: _____

Deployed Station/Unit: _____ **Duties while deployed:**

Date arrived in theater (dd/mmm/yyyy): _____

EBOLA VIRUS DISEASE EXPOSURE RISK EVALUATION
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Deployer's SSN (Last 4 digits): _____

COMPLETED BY DESIGNATED MEDICAL PROVIDER ONLY – Provider Review, Interview, Exposure Risk Evaluation

PART I - A : Ebola Virus Disease Risk Assessment [Mark all that apply. If "Yes" document date, time & type of MOST recent exposure.]

	SOME RISK OF EXPOSURE: One or more of the following within the past 21 days.	Yes	No
1.	**Close contact with an Ebola Virus Disease (EVD) patient in any of the following settings: household, living quarters, work, or community? If yes, document date, time and type of contact and/or exposure.** Date (dd/mmm/yyyy): _____ Time: _____ Type: _____ **Close contact is defined as:** a. Being within approximately 3 feet (1 meter) of an EVD patient for a prolonged period of time while not wearing recommended personal protective equipment (PPE) or PPE was compromised. b. Having direct brief contact (e.g., shaking hands) with an EVD patient while not wearing recommended personal protective equipment (PPE) or PPE was compromised. **(Brief interactions, such as walking by a person, do not constitute close contact.)**	◯	◯
2.	**Other close contact with EVD patients in healthcare facilities or community settings? If yes, document date, time and type of contact and/or exposure.** Date (dd/mmm/yyyy): _____ Time: _____ Type: _____ **Close contact is defined as:** a. Being within approximately 3 feet (1 meter) of an EVD patient or within the patient's room or care area for a prolonged period of time (e.g., health care personnel, household members) while not wearing recommended personal protective equipment (PPE) (standard droplet and contact precautions) or PPE was compromised. b. Having direct brief contact (e.g., shaking hands) with an EVD patient while not wearing recommended personal protective equipment (PPE) or PPE was compromised. **(Brief interactions, such as walking by a person or moving through a hospital, do not constitute close contact.)**	◯	◯
	HIGH RISK OF EXPOSURE: One or more of the following within the past 21 days.	**Yes**	**No**
3.	**Percutaneous (e.g., needle stick) or mucous membrane exposure to blood or body fluids of an EVD patient? If yes, document date, time and type of contact and/or exposure.** Date (dd/mmm/yyyy): _____ Time: _____ Type: _____	◯	◯
4.	**Direct skin contact with, or exposed to, blood or body fluids of an EVD patient without appropriate personal protective equipment (PPE) or PPE was compromised? If yes, document date, time and type of contact and/or exposure.** Date (dd/mmm/yyyy): _____ Time: _____ Type: _____	◯	◯
5.	**Processing blood or body fluids of a confirmed EVD patient without appropriate personal protective equipment (PPE), standard biosafety precautions or PPE was compromised? If yes, document date, time and type of contact and/or exposure.** Date (dd/mmm/yyyy): _____ Time: _____ Type: _____	◯	◯
6.	**Direct contact with a dead body without appropriate personal protective equipment (PPE), or PPE was compromised in a country where an EVD outbreak is occurring? If yes, document date, time and type of contact and/or exposure.** Date (dd/mmm/yyyy): _____ Time: _____ Type: _____	◯	◯

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PART I -B: Ebola Virus Disease Clinical Evaluation [Mark all that apply.]

		Yes	No
1.	**Ask "Are you currently experiencing any of the following signs and symptoms?"**		
	a. Fever (temperature of > 100.4 °F) ◯ **Don't Know**	◯	◯
	b. Subjective fever (e.g., chills, night sweats)	◯	◯
	c. Severe headache	◯	◯
	d. Joint and muscle aches	◯	◯
	e. Abdominal/stomach pain	◯	◯
	f. Vomiting	◯	◯
	g. Diarrhea	◯	◯
	h. Unexplained bruising or bleeding	◯	◯
	i. New skin rash	◯	◯
	j. Other (describe in block #5)	◯	◯
2.	**Ask "Have you taken any fever-reducing medications within the past twelve [12] hours?"** (e.g., aspirin, Tylenol, Motrin, Ibuprofen)	◯	◯
3.	**Conduct and record temperature check.** Temperature: _____ Time: _____		
4.	**Date and time of onset of symptoms.** Date(dd/mmm/yyyy): _____ Time: _____ ◯ N/A		
5.	**Comments:**		

D R A F T

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Deployer's SSN (Last 4 digits): _____

PART I-C: Ebola Virus Disease Risk Category [Mark ONLY one.]

Disposition Guidance: Document risk category in the individual's medical record.

◯ **No Known Exposure**	**Asymptomatic:** • Return to duty and continue twice daily unit monitoring for exposure risk and clinical symptoms. **Symptomatic (Fever WITH or WITHOUT other symptoms)** • Evaluation by medical authority. • Implement infection control precautions.
◯ **Some Risk of Exposure** **("Yes" to questions 1 or 2, PART I-A)**	**Asymptomatic:** • Evaluate for potential medical evacuation IAW official policy. • If determined to be "minimal risk" return to duty and begin twice daily monitoring by medical authorities for 21 days. **Symptomatic: (Fever WITH or WITHOUT other symptoms)** • Evaluation by medical authority. • **Isolate and separate from "High Risk individuals.** Implement infection control precautions. • Evacuate from theater via regulated movement to a DoD designated medical facility capable of providing care for EVD patients IAW official policy.
◯ **High Risk Exposure** **("Yes" to questions 3, 4, 5, or 6, PART I-A)**	**Asymptomatic:** D R A F T • Evaluation by medical authorities. • **Quarantine** and evacuate from theater via regulated movement to a DoD designated facility capable of monitoring for signs and symptoms and providing care for EVD patients IAW official policy. **Symptomatic: (Fever or other symptoms)** • Evaluation by medical authorities. • **Isolate and separate from "Some Risk" individuals.** Implement infection control precautions. • Evacuate from theater via regulated movement to a DoD designated facility capable of providing care for EVD patients IAW official policy.

Provider's Name: _____ **Date (dd/mmm/yyyy):** _____ **Time:** _____

Title: ◯ MD ◯ DO ◯ PA ◯ Nurse Practitioner ◯ Adv Practice Nurse ◯ Other: _____

◯ **I certify this assessment process has been completed.** **Provider's Signature:** _____